DRAFT 08-06

HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Kansas Medical Assistance Programs

Provider Line: **1-800-933-6593**
Consumer Line: **1-800-766-9012**

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Remicade Prior Authorization Request Form

Consumer Name: _____

Consumer Medicaid ID #: _____ Date Of Birth: _____/_____/_____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Drug Name: _____ NDC Requested: _____

-OR-

Billing provider's Name (Physicians **OR** Facility):_____

Provider Medicaid ID#: _____ Phone Number: (_____)_____

Fax Number: (_____)_____J-Code requesting: _____ # of units requesting: _____

1. Please indicate the diagnosis and severity for which Remicade is being prescribed (no dx codes):

_____

2. Is the consumer taking methotrexate? Yes ☐ No ☐

3. For RA and/or for Psoriatic Arthritis, documentation of inadequate response to one or more DMARD's (Disease Modifying Antirheumatic Drugs) such as methotrexate, hydroxychloroquine, sulfasalazine, or gold salts:_____

_____

4. For Ankylosing Spondylitis, documentation of inadequate response to two or more NSAIID's or adverse drug reaction._____

_____

5. Prescribed by a Rheumatologist: Yes ☐ No ☐

6. For Crohn's Disease or Ulcerative Colitis, documentation of inadequate response to conventional therapies:

_____

_____

7. TB skin test results: Date: _____ Positive ☐ Negative ☐

Prescribing Physican's name:_____ Medicaid ID#_____
Prescribing Physican's phone #(_____)_____Fax #(_____)_____

Prescribing Physician's Signature: _____ Date: ___/___/_____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within

15 working days, the case will be denied.